BES Form 928
July 04

MEDICAID CANCER PROGRAM REFERRAL FORM

Date Sent to Medicaid _____

Date sent to UCCP_____

Name:_____ SSN: _____

D.O.B. _____ Phone Number: _____

Address: _____

_____

City County State Zip

Annual Household Income: _____ Family size:_____

Health Insurance: ☐ Yes ☐ No

☐ This individual has been screened and found to be in need of treatment for breast/cervical cancer by a contracted provider of the Utah Cancer Control Program.

☐ This individual has been screened and found to be in need of treatment for pre-cancerous conditions for breast/cervical cancer (entitles a woman to three months of eligibility under the Medicaid Cancer program beginning with the month of diagnosis).

_____ _____/_____/_____

Signature & Phone Number of UCCP Case Manager Date

This person is ❑ eligible ❑ not eligible for Medicaid benefits.

Effective date of Medicaid Eligibility: _____

Eligibility is for which Medicaid Program? (specify if the client is under the Medicaid Breast and Cervical Treatment Act-Medicaid Cancer Program): _____

If not eligible for Medicaid , list reason:_____

_____ _____/_____/_____

Signature & Phone Number of Medicaid Worker Date

Important: Please **fax this form back** to UCCP as soon as it has been completed. Thanks!
Fax: 801-538-9495